HOUSE BILL NO. 618

INTRODUCED BY S. AUGARE

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING GREATER THAN A MAJORITY OF HEALTH INSURANCE PREMIUMS TO BE PAID OUT IN MEDICAL CARE COSTS; PROVIDING FOR DISTRIBUTION OF ANY EXCESS; AUTHORIZING THE INSURANCE COMMISSIONER TO APPROVE RATES PRIOR TO IMPLEMENTATION; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-2-704, 33-2-1903, 33-18-209, 33-22-101, 33-30-102, 33-30-306, AND 33-31-111, MCA; AND PROVIDING AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Premium percentage for medical coverage -- notice -- dividends.** (1) A health insurance issuer that issues or renews a policy, certificate, or membership contract for health insurance coverage covering a resident of this state, but excluding excepted benefits, shall pay out in its aggregate benefits for covered medical care 85% of the collected premium minus the premium tax required under 33-2-705 and the assessment due under 33-22-1513.

(2) A health insurance issuer shall provide within the policy, certificate, or membership contract a notice in substantially the following format:

NOTICE REQUIRED BY MONTANA LAW

Montana law requires health insurance issuers to expend 85% of total premium revenues on actual medical care expenses.

(3) A health insurance issuer filing a report under 33-2-704, 33-30-107, or 33-31-211 shall include the percent of premium paid out to date for the year ending on the previous December 31, minus the premium tax required under 33-2-705 and the assessment due under 33-22-1513.

(4) (a) If the ratio reported under subsection (3) is less than 85% of the collected premium or a percentage determined as provided in subsection (5), the health insurance issuer shall, subject to subsection (6), issue a dividend or a credit against future premiums for all group policyholders and holders of individual policies, certificates, or membership contracts as provided in subsection (4)(b) to the extent necessary to ensure that the dividend plus the aggregate benefits paid in the previous calendar year, minus the premium tax due under

33-2-705 and the assessment due under 33-22-1513, equal 85% of premiums collected for that year or a percentage determined as provided in subsection (5).

(b) The dividend or credit against future premiums described under subsection (4)(a) must be paid to group policyholders and holders of individual policies, certificates, or membership contracts by December 31 of the year after the calendar year in which the specified ratio of medical care expenditures to premiums was not met. In the case of cancellation or termination by a group policyholder or a holder of an individual policy, certificate, or membership contract, the dividend must be distributed among all group policyholders and holders of individual policies, certificates, or membership contracts.

(5) The commissioner, after reviewing information reported by the health insurance issuer pursuant to 33-2-1903 and [section 2], may adjust the requirement to a ratio other than 85% by an amount that the commissioner determines necessary to further the goal of providing the maximum amount of health care for each dollar of health insurance premium charged, consistent with the model for maintaining risk-based capital levels issued by the national association of insurance commissioners. The commissioner may not adjust a ratio by more than 2% in any calendar year.

(6) (a) If a health insurance issuer reports a ratio that is less than 85% of the collected premiums or the percentage determined by the commissioner in subsection (5) and demonstrates to the satisfaction of the commissioner that the health insurance issuer's risk-based capital level is consistent with the model for maintaining risk-based capital levels issued by the national association of insurance commissioners, the commissioner may allow the health insurance issuer to use some or all of the money that would otherwise be paid to group policyholders or holders of individual policies, certificates, or membership contracts, to replenish the health insurance issuer's risk-based capital level.

(b) The payment under subsection (6)(a) may not be used to replenish a risk-based capital level beyond a level that is consistent with the model for maintaining risk-based capital levels issued by the national association of insurance commissioners.

(7) The commissioner may hold hearings and take action to ensure compliance with this section as provided in Title 33, chapter 1.

NEW SECTION. **Section 2. Prior rate approval.** (1) (a) A health insurance issuer shall file with the commissioner a complete and detailed description of the health insurance issuer's rates, rating practices, rating plans, and renewal underwriting practices in a form and manner as provided in subsection (7) and at a time

prescribed by the commissioner.

(b) Each health insurance issuer shall maintain information and documentation that demonstrates that the health insurance issuer's rating methods and practices are based on commonly accepted actuarial assumptions and are in accordance with sound actuarial principles and that the rates are not excessive, inadequate, discriminatory, or otherwise not in compliance with the provisions of this code.

(2) (a) Rates must be submitted annually to the commissioner to determine compliance with [section 1].

(b) A rate increase must be submitted to the commissioner at least 60 days prior to its proposed implementation.

(c) If the insurance commissioner does not approve or disapprove the rate filings within the 60-day period, the health insurance issuer may implement and reasonably rely on the rate under the condition that the commissioner may require correction of any deficiencies in the rate filing upon later review if the commissioner determines that the rate is excessive, inadequate, discriminatory, or otherwise not in compliance with the provisions of this code.

(3) A prospective rate adjustment is the sole remedy for rate deficiencies pursuant to subsection (2)(b). If the commissioner finds deficiencies in the rate filing after a 60-day period, the commissioner shall provide notice to the health insurance issuer. The health insurance issuer shall correct the rate on a prospective basis.

(4) After providing the information required in subsection (1), a health insurance issuer is not required to file a rate for preapproval by the commissioner if the rate does not involve a requested rate increase and the health insurance issuer may implement the rate upon filing it with the commissioner, subject to the provisions of [section 1].

(5) The commissioner may disapprove a rate filing if one or more of the following conditions apply:

(a) the benefits provided are not reasonable, including in relationship to the premiums charged, as determined pursuant to [section 1];

(b) the requested rate increase contains a provision that the commissioner considers excessive, inadequate, discriminatory, or otherwise not in compliance with the provisions of [section 1] and this code. In determining if a provision is excessive or inadequate, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve and reserve for losses, surpluses, executive salaries and bonuses, expected benefits ratios, including the medical loss ratio provided for in [section 1], and any other appropriate actuarial factors as

determined by current actuarial standards of practice and adopted by rule.

(c) the actuarial reasons and the data based on Montana claims experience do not justify the necessity for the requested rate increase; or

(d) the rate filing is incomplete, as provided in subsection (6).

(6) The commissioner may require a resubmission for approval if any of the following conditions apply:

(a) the health insurance issuer fails to supply the information required by this section. The commissioner shall determine the completeness of a filing no later than 30 days after submission of the filing for review.

(b) the commissioner determines that the substantive content contains deficiencies. If the commissioner determines that the filing contains substantive deficiencies, the commissioner shall identify the deficiency and inform the health insurance issuer of the deficiency on or before 45 days have expired from the date of the filing. A health insurance issuer shall correct a deficiency, including a deficiency discovered after 45 days have expired, on a prospective basis.

(7) (a) Unless exempted for an emergency situation, rates must be filed electronically in a format made available by the commissioner, as described by the commissioner by rule.

(b) A rate filing summary must be posted on the commissioner's website, and the public must be provided an opportunity to inspect a rate filing and any supporting information.

(8) Rates are not inadequate unless:

(a) the rates clearly are insufficient to sustain projected losses and expenses; or

(b) the use of the rates, if continued, is determined by the commissioner to have a tendency to create a monopoly in the market.

(9) A penalty may not be applied for a violation of this section if the violation was not willful.

(10) The commissioner may adopt rules to implement [section 1] and this section.

Section 3. Section 33-2-704, MCA, is amended to read:

"33-2-704. Insured lives <u>and medical expense</u> reporting requirement. On or before March 1 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report<u>:</u>

<u>(1)</u> the number of Montana residents insured on February 1 under any policy of individual or group disability insurance, including excess of loss or stop-loss insurance policies covering disability insurance<u>; and</u>

<u>(2) the ratio of medical care expenditures paid out to total premiums collected minus the premium tax required under 33-2-705 or the assessment due under 33-22-1513</u>."

Section 4. Section 33-2-1903, MCA, is amended to read:

"33-2-1903. RBC reports. (1) Each domestic insurer shall, on or before each March 1 filing date, prepare and submit to the commissioner a report of ~~its~~ the domestic insurer's RBC levels as of the end of the previous calendar year in a form and containing information as required by the RBC instructions. In addition, each domestic insurer shall file ~~its~~ the RBC report:

(a) with the NAIC in accordance with the RBC instructions; and

(b) with the insurance commissioner in any state in which the insurer is authorized to do business if that insurance commissioner has notified the insurer of the request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file ~~its~~ the domestic insurer's RBC report with that state; or

(ii) the March 1 filing date.

(2) A life and disability insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) A property and casualty insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and other relevant risks that are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(4) An excess of capital over the amount produced by the risk-based capital requirements contained in this part and the formulas, schedules, and instructions referenced in 33-2-1906 through 33-2-1913 is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this part. Additional capital is used and useful in the insurance business and helps to secure an insurer against

various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this part.

(5) If a domestic insurer files an RBC report that in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. An RBC report so adjusted is referred to as an adjusted RBC report.

(6) A health insurance issuer, as defined in 33-22-140, that issues or renews a policy, certificate, or membership contract covering a resident of this state shall file a risk-based capital report with the commissioner for use in determining if the provisions of [section 1] result in rates that are inadequate as provided in [section 2]."

Section 5. Section 33-18-209, MCA, is amended to read:

"33-18-209. Exceptions to discrimination and rebates provision. ~~Nothing in~~ The provisions of 33-18-206 and 33-18-208 ~~shall~~ may not be construed as including within the definition of discrimination or rebates any of the following practices:

(1) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that ~~any such~~ the bonuses or abatement of premiums ~~shall~~ must be fair and equitable to policyholders and for the best interests of the insurer;

(2) in the case of life insurance policies issued on the industrial debit, preauthorized check, bank draft, or similar plans, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer or by preauthorized check, bank draft, or similar plans, in an amount ~~which~~ that fairly represents the saving in collection expense;

(3) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience ~~thereunder~~, at the end of the first or any subsequent policy year of insurance ~~thereunder~~, which may be made retroactive only for ~~such~~ that contract or policy year;

(4) reduction of premium rate for policies of large amount ~~but~~, subject to the provisions of [section 1], and adjusted to not ~~exceeding~~ exceed the savings ~~in~~ related to issuance and administration expenses reasonably attributable to ~~such~~ the large-amount policies as compared with policies ~~of~~ for a similar plan issued in smaller amounts;

(5) issuing life or disability insurance policies on a salary savings or payroll deduction plan at a reduced

rate reasonably commensurate with the savings made by the use of ~~such~~ a salary savings or payroll deduction plan."

Section 6. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. (1) Subject to subsection (2), parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, 33-22-140, 33-22-141, 33-22-142, 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

(a) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(b) any group or blanket policy;

(c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

(i) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract;

(d) reinsurance.

(2) Sections 33-22-150 through 33-22-152, ~~and~~ 33-22-301, and [section 1] apply to group or blanket policies."

Section 7. Section 33-30-102, MCA, is amended to read:

"33-30-102. Application of this chapter -- construction of other related laws. (1) All health service corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: 33-2-1212; 33-2-1903; 33-3-307; 33-3-308; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; [sections 1 and 2], Title 33, chapter 2, part 19; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 15, 18, 19, and 22, except 33-22-111.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event

of a conflict, the provisions of this chapter prevail."

Section 8. Section 33-30-306, MCA, is amended to read:

"33-30-306. Discrimination between individuals -- restrictions -- ratesetting by commissioner prohibited. (1) ~~No~~ A person may not knowingly make or permit any unreasonable discrimination between individuals in any classification ~~which~~ that may be established by a health service corporation and of essentially the same condition of health in the amount of dues or rates charged for any membership contract or in the benefits payable ~~thereunder~~ under the membership contract or in any of the terms and conditions of ~~such~~ the contract or in any other manner ~~whatever~~.

(2) ~~Nothing herein contained shall, however, restrict the right of a~~ A health service corporation has within the discretion of its board of directors the right to:

(a) limit or define the classes of persons who ~~shall be~~ are eligible to become members~~, to~~; and

(b) limit and ~~to~~ define the benefits ~~which it will furnish,~~ that the health service corporation is to provide and define ~~such~~ the benefits ~~as it undertakes to furnish into~~ by classes or kinds.

(3) A health service corporation may make available to its members health services~~,~~ or reimbursement ~~therefor,~~ for health services ~~as~~ that the board of directors ~~of that corporation~~ may approve.

~~(3)~~(4) ~~Nothing contained in~~ The provisions of subsection (1) ~~includes~~ do not include within the definition of discrimination any of the following practices:

(a) readjustment of the rate of payment for membership in a health service corporation under a group contract based on the loss or expense experience ~~thereunder~~ at the end of the first or any subsequent contract year, ~~thereunder~~ which may be made retroactive only for that contract year;

(b) in the case of membership contracts issued on the preauthorized bank draft or similar plans, making allowance to members in an amount ~~which~~ that fairly represents the saving in collection expense;

(c) reduction of the rate of payment for group contracts covering a large number of members, ~~but not exceeding~~ subject to the provisions of [section 1] and adjusted to not exceed the savings in administrative expenses reasonably attributable to these contracts as compared with contracts offering similar benefits to smaller numbers of members;

(d) issuing individual membership contracts on a ~~"~~salary savings~~"~~ or payroll deduction plan reasonably commensurate with the savings made by use of ~~such~~ the salary savings or payroll deduction plan.

(4) ~~Nothing in this chapter gives the~~ Except as provided in [sections 1 and 2], the commissioner does

not have the power to fix and determine a rate level by classification or otherwise."

Section 9. Section 33-31-111, MCA, is amended to read:

"33-31-111. (Temporary) Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36, except as provided in 33-22-262; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Except as provided in 33-22-262, the provisions of Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-704, 33-2-1114, 33-2-1211, 33-2-1212, 33-2-1903, 33-2-1909, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-152, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524,

33-22-526, ~~and~~ 33-22-706, and [sections 1 and 2] apply to health maintenance organizations. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-31-111. (Effective July 1, 2009) Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-704, 33-2-1114, 33-2-1211, 33-2-1903, 33-2-1909, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-152, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524, 33-22-526, ~~and~~ 33-22-706, and [sections 1 and 2] apply to health maintenance organizations."

NEW SECTION. **Section 10. Codification instruction.** [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 and 2].

NEW SECTION. **Section 11. Applicability.** [This act] applies to insurance policies, certificates, or membership contracts issued or renewed on or after January 1, 2010.

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